

Facility Name & ID Number Hearthstone Manor

0027664 Report Period Beginning: ##### Ending: 6/30/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>29</u>	Skilled (SNF)	<u>29</u>	<u>10,585</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>46</u>	Intermediate (ICF)	<u>46</u>	<u>16,790</u>	3
4		Intermediate/DD			4
5	<u>63</u>	Sheltered Care (SC)	<u>63</u>	<u>22,995</u>	5
6		ICF/DD 16 or Less			6
7	138	TOTALS	138	50,370	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>37</u>	<u>5,728</u>		<u>5,765</u>	8
9	SNF/PED					9
10	ICF	<u>5,824</u>	<u>10,498</u>	<u>21</u>	<u>16,343</u>	10
11	ICF/DD					11
12	SC	<u>1,120</u>	<u>10,954</u>		<u>12,074</u>	12
13	DD 16 OR LESS					13
14	TOTALS	6,981	27,180	21	34,182	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.86%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started / /1903

J. Was the facility purchased or leased after January 1, 1978? YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year? YES ☐ NO ☒ If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 6/30/2001 Fiscal Year: 6/30/2001

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **Hearthstone Manor** # **0027664** Report Period Beginning: **7/1/2000** Ending: **6/30/2001**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	187,891	26,929	100,330	315,150		315,150		315,150			1
2	Food Purchase		137,152		137,152		137,152	(5,662)	131,490			2
3	Housekeeping	102,256	25,317	89	127,662		127,662		127,662			3
4	Laundry	55,922	6,059		61,981		61,981		61,981			4
5	Heat and Other Utilities			108,687	108,687		108,687	5,236	113,923			5
6	Maintenance			94,640	94,640		94,640	49,676	144,316			6
7	Other (specify):*											7
8	TOTAL General Services	346,069	195,457	303,746	845,272		845,272	49,250	894,522			8
	B. Health Care and Programs											
9	Medical Director			9,890	9,890		9,890		9,890			9
10	Nursing and Medical Records	1,238,510	63,332	213,640	1,515,482		1,515,482		1,515,482			10
10a	Therapy											10a
11	Activities	118,909	3,933	3,833	126,675		126,675		126,675			11
12	Social Services	90,370	76	727	91,173		91,173		91,173			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,447,789	67,341	228,090	1,743,220		1,743,220		1,743,220			16
	C. General Administration											
17	Administrative	87,779		531,840	619,619		619,619	(429,278)	190,341			17
18	Directors Fees											18
19	Professional Services			128,705	128,705		128,705	36,611	165,316			19
20	Dues, Fees, Subscriptions & Promotions			100,585	100,585		100,585	(73,104)	27,481			20
21	Clerical & General Office Expenses	104,077	36,017	109,931	250,025		250,025	133,471	383,496			21
22	Employee Benefits & Payroll Taxes			337,521	337,521		337,521	130,397	467,918			22
23	Inservice Training & Education			203	203		203		203			23
24	Travel and Seminar			15,887	15,887		15,887	13,901	29,788			24
25	Other Admin. Staff Transportation							2,084	2,084			25
26	Insurance-Prop.Liab.Malpractice			12,418	12,418		12,418	7,781	20,199			26
27	Other (specify):*											27
28	TOTAL General Administration	191,856	36,017	1,237,090	1,464,963		1,464,963	(178,137)	1,286,826			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,985,714	298,815	1,768,926	4,053,455		4,053,455	(128,887)	3,924,568			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			147,203	147,203		147,203	(10,775)	136,428			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,633	22,633		22,633	(22,633)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,320	2,320		2,320		2,320			35
36	Other (specify):*											36
37	TOTAL Ownership			172,156	172,156		172,156	(33,408)	138,748			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		256,215		256,215		256,215		256,215			39
40	Barber and Beauty Shops	12,778	1,443		14,221		14,221	(14,221)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,063	41,063		41,063		41,063			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	12,778	257,658	41,063	311,499		311,499	(14,221)	297,278			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,998,492	556,473	1,982,145	4,537,110		4,537,110	(176,516)	4,360,594			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,662)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(22,633)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(14,727)	40		16
17	Non-Care Related Fees	(10,775)	30		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(46,913)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)	20		24
25	Fund Raising, Advertising and Promotional	(15,679)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(8,947)	20		28
29	Other-Attach ScheduleCorporate Allocation	(531,840)	17		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (669,176)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$ 26,621		31
32	Donated Goods-Attach Schedule*	1,725		32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	492,660		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 521,006		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (148,170)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Hearthstone Manor

ID#	0027664
Report Period Beginning:	7/1/2000
Ending:	6/30/2001

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

6/30/2001

[illegible]

Summary B

6/30/2001

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Woodstock Christian		
				Life Services	Woodstock	Corporate Office
				Hearthstone Village	Woodstock	Independent Lvg
				Woodstock Early		
				Learning Center	Woodstock	Day Care

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Maintenance	\$	Woodstock Christian Life Services	100.00%	\$ 49,676	\$ 49,676	1
2	V	22	Employee Benefits		Woodstock Christian Life Services	100.00%	130,397	130,397	2
3	V	26	Insurance		Woodstock Christian Life Services	100.00%	7,781	7,781	3
4	V	5	Utilities		Woodstock Christian Life Services	100.00%	5,236	5,236	4
5	V	30	Depreciation		Woodstock Christian Life Services	100.00%	0		5
6	V	33	Real Estate Taxes		Woodstock Christian Life Services	100.00%	0		6
7	V	17	Administrative		Woodstock Christian Life Services	100.00%	102,562	102,562	7
8	V	21	Clerical & General Office		Woodstock Christian Life Services	100.00%	133,471	133,471	8
9	V	40	Other - Special Events		Woodstock Christian Life Services	100.00%	506	506	9
10	V	20	Fees, Subscriptions, Promotions		Woodstock Christian Life Services	100.00%	10,435	10,435	10
11	V	19	Professional Fees		Woodstock Christian Life Services	100.00%	36,611	36,611	11
12	V	24	Travel & Seminars		Woodstock Christian Life Services	100.00%	13,901	13,901	12
13	V	25	Other Administrative		Woodstock Christian Life Services	100.00%	2,084	2,084	13
14	Total			\$			\$ 492,660	\$ * 492,660	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Hearthstone Manor # 0027664 Report Period Beginning: 7/1/2000 Ending: 6/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Woodstock Christian Life Services
Street Address 318 Christian Way
City / State / Zip Code Woodstock, IL 60098
Phone Number (815) 338-1090
Fax Number (815) 338-0023

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Corporate Revenue	857,807	3	\$ 80,122	\$	531,840	\$ 49,676	1
2	22	Employee Benefits	Corporate Revenue	857,807	3	210,318		531,840	130,397	2
3	26	Insurance	Corporate Revenue	857,807	3	12,550		531,840	7,781	3
4	5	Utilities	Corporate Revenue	857,807	3	8,445		531,840	5,236	4
5	30	Depreciation	Corporate Revenue	857,807	3	0		531,840	0	5
6	33	Real Estate Taxes	Corporate Revenue	857,807	3	0		531,840	0	6
7	17	Administrative	Corporate Revenue	857,807	3	165,422	165,422	531,840	102,562	7
8	21	Clerical & General Office	Corporate Revenue	857,807	3	215,276	142,975	531,840	133,471	8
9	40	Other - Special Events	Corporate Revenue	857,807	3	816		531,840	506	9
10	20	Fees, Subscriptions, Promotions	Corporate Revenue	857,807	3	16,831		531,840	10,435	10
11	19	Professional Fees	Corporate Revenue	857,807	3	59,050		531,840	36,611	11
12	24	Travel & Seminars	Corporate Revenue	857,807	3	22,421		531,840	13,901	12
13	25	Other Administrative	Corporate Revenue	857,807	3	3,362		531,840	2,084	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 794,613	\$ 308,397		\$ 492,660	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10			
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
	A. Directly Facility Related														
	Long-Term														
1							\$		\$			\$	1		
2													2		
3													3		
4													4		
5													5		
	Working Capital														
6	Fifth Thirds Bank		X	Renovation Financing	\$4,334.00	2/2001		146,651		123,342	2/2004	0.0875	11,812	6	
7	Fifth Thirds Bank		X	Renovation Financing	\$4,794.00	1/1999		209,791		102,567	4/2003	0.0725	9,042	7	
8	Fifth Thirds Bank		X	Renovation Financing	\$264.00	12/2000		20,495		19,965	1/2004	0.0975	1,779	8	
9	TOTAL Facility Related				\$9,392.00		\$	376,937	\$	245,874			\$	22,633	9
	B. Non-Facility Related*														
10														10	
11														11	
12														12	
13														13	
14	TOTAL Non-Facility Related						\$		\$				\$		14
15	TOTALS (line 9+line14)						\$	376,937	\$	245,874			\$	22,633	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2000 report.				\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	2
3. Under or (over) accrual (line 2 minus line 1).				\$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1996		8	
		1997		9	
		1998		10	
		1999		11	
		2000		12	
				13	FROM R. E. TAX STATEMENT FOR 2000 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Hearthstone Manor

COUNTY

McHenry

FACILITY IDPH LICENSE NUMBER

0027664

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.			\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,000

B. General Construction Type:

Exterior	<u>Masonry</u>	Frame	<u> </u>	Number of Stories	<u>3</u>
-----------------	----------------	--------------	-------------------------	--------------------------	----------

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Woodstock Christian Life Services - Corporate Division

Hearthstone Village - Independent Living

Woodstock Early Learning Center - Day Care

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred:	2. Number of Years Over Which it is Being Amortized:
----------------------------------	---

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	60,000	1903	\$ 5,372	1
2					2
3	TOTALS	60,000		\$ 5,372	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hearthstone Manor

0027664

Report Period Beginning:

7/1/2000

Ending:

6/30/2001

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	10		1950	1950	\$ 150,823	\$	40	\$	\$	150,823	4
5	90		1973	1973	796,110	19,903	40	19,903		577,184	5
6	38		1976	1976	751,053	18,776	40	18,776		488,179	6
7											7
8											8
	Improvement Type**										
9	Sprinkler System			1977	2,935	117	25	117		2,926	9
10	Air Conditioning			1977	10,374		10			10,374	10
11	Roof			1978	4,656		20			4,656	11
12	Roof			1978	7,536		20			7,536	12
13	Boiler			1978	8,498		20			8,498	13
14	Sprinkler System			1980	10,353	414	25	414		9,108	14
15	Office Remodeling			1980	5,218	130	40	130		2,877	15
16	Roof			1981	5,100		10			5,100	16
17	Parking Lot			1982	3,549	89	40	89		1,941	17
18	Roof Additions			1983	6,560	164	40	164		3,034	18
19	Roof			1984	4,690		10			4,690	19
20	Kitchen			1984	187	9	20	9		152	20
21	Kitchen			1985	1,415	35	40	35		950	21
22	Sign			1985	855		5			855	22
23	Remodeling Second Floor			1985	10,026		10			10,026	23
24	Activity Room			1985	1,044	18	15	18		1,062	24
25	Remodeling Second Floor			1985	1,735	87	20	87		1,469	25
26	Dining Room Remodel			1986	27,607		10			27,607	26
27	Solarium			1986	15,216		10			15,216	27
28	Kitchen			1986	5,749	287	20	287		4,306	28
29	Solarium			1987	45,713	1,143	40	1,143		17,144	29
30	HVAC			1987	3,931	197	20	197		2,954	30
31	Water Heater			1987	1,258	84	15	84		1,272	31
32	Roof			1987	11,828		10			11,828	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hearthstone Manor

0027664

Report Period Beginning:

7/1/2000

Ending:

6/30/2001

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Re-Key Locks	1987	\$ 1,004	\$	10	\$	\$	\$ 1,004	37
38	Renovations Room 241	1987	629	41	15	41		629	38
39	Parking Lot	1987	3,291	219	15	219		3,286	39
40	Roof	1988	12,550		10			12,550	40
41	Remodel Employee Lounge	1988	890		10			890	41
42	Courtyard landscaping	1987	1,406		10			1,406	42
43	Water Meters	1989	2,820		10			2,820	43
44	Roof Repair	1990	1,255		10			1,255	44
45	Thermostats	1991	1,264	66	10	66		1,264	45
46	Roof Repair	1992	980	98	10	98		980	46
47	Thermostats	1992	1,481	149	10	149		1,481	47
48	Drop Ceiling	1992	370	37	10	37		352	48
49	Windows	1992	607	61	10	61		579	49
50	Roof Repair	1992	608	61	10	61		538	50
51	Smoker Room	1992	973	97	10	97		848	51
52	Nurse Station	1992	359	36	10	36		315	52
53	Roof Repair	1992	720	72	10	72		624	53
54	Smoker Room	1992	216	22	10	22		191	54
55	Brick Smoker Room	1992	325	33	10	33		286	55
56	Parking Lot Expansion	1992	577	38	15	38		328	56
57	Roof Repair	1993	800	80	10	80		630	57
58	Windows	1993	317	32	10	32		251	58
59	Roof Repair	1993	1,715	172	10	172		1,330	59
60	Generator Repair	1993	1,049	105	10	105		798	60
61	Water Heater	1994	3,240	324	10	324		2,376	61
62	Courtyard	1994	819	82	10	82		588	62
63	Alarm System	1994	1,391	139	10	139		966	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,935,675	\$ 43,417		\$ 43,417	\$	\$ 1,410,332	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Hearthstone Manor

0027664

Report Period Beginning:

7/1/2000

Ending:

6/30/2001

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,935,675	\$ 43,417		\$ 43,417	\$	\$ 1,410,332	1
2	Fire Doors	1994	437	44	10	44		308	2
3	Roof Repair	1994	1,259	126	10	126		856	3
4	Plumbing	1995	10,741		5			10,741	4
5	Roof Repair	1995	1,170	117	10	117		692	5
6	Roof Repair	1995	11,299	1,130	10	1,130		6,592	6
7	Roof Repair	1995	12,340	1,234	10	1,234		7,095	7
8	Roof Repair	1995	861	86	10	86		487	8
9	Electrical Repair	1995	15,122	1,512	10	1,512		8,442	9
10	Roof Repair	1996	3,500	350	10	350		1,925	10
11	Doors	1996	2,685	269	15	269		1,479	11
12	Fire Doors	1996	457	46	20	46		253	12
13	Doors	1996	1,649	110	10	110		587	13
14	Architect Service	1996	13,331	667	20	667		3,528	14
15	Roof Repair	1996	5,380	538	20	538		2,756	15
16	Roof Replacement	1996	27,341	1,367	20	1,367		6,722	16
17	Plumbing	1996	10,960	1,096	20	1,096		5,385	17
18	Architect Service	1996	1,332	67	20	67		328	18
19	Roof Repair	1996	1,758	176	20	176		854	19
20	Alum. Gutter-downspout	1996	1,650	165	20	165		786	20
21	Architect Service	1996	1,122	56	20	56		269	21
22	Roof Repair	1996	540	54	20	54		261	22
23	Rooftop HVAC Replacement	1996	52,688	2,634	20	2,634		12,516	23
24	New Door	1996	3,042	304	20	304		1,441	24
25	Roof Replacement	1996	25,941	1,297	20	1,297		6,052	25
26	Firestops Replacement	1996	3,553	355	10	355		1,660	26
27	Architect Service	1996	475	24	20	24		112	27
28	Exit Lights	1996	2,737	274	10	274		1,257	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,149,045	\$ 57,515		\$ 57,515	\$	\$ 1,493,716	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Hearthstone Manor

0027664

Report Period Beginning:

7/1/2000

Ending:

6/30/2001

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,149,045	\$ 57,515		\$ 57,515	\$	\$ 1,493,716	1
2	Architect Service	1996	750	38	20	38		173	2
3	HVAC	1996	77,291	3,865	20	3,865		17,714	3
4	New Sidewalk	1996	986	66	20	66		198	4
5	Parking lot repair	1996	1,623	162	20	162		760	5
6	S.M. Sign Maintenance	1996	308	62	20	62		283	6
7	Labor-Roof replacement	1997	12,255	1,225	20	1,225		5,512	7
8	Architect Service	1997	1,775	178	20	178		867	8
9	Sunroom painting	1997	2,145	215	20	215		932	9
10	Asbestos repair	1997	715	72	20	72		312	10
11	Heating	1998	5,787	289	20	289		1,084	11
12	Ductwork & elec.	1998	3,370	337	20	337		1,208	12
13	Rebuild roof unit	1998	2,235	223	20	223		800	13
14	3rd floor project	1998	10,019	501	20	501		1,795	14
15	IDPH-Bldg Project Fees	1998	2,712	136	20	136		487	15
16	Shayman-Contractors	1998	10,000	500	20	500		1,793	16
17	Century Tile	1998	461	46	20	46		161	17
18	Handi-Hut-Shelter	1998	7,488	749	20	749		2,496	18
19	Signage	1998	412	82	10	82		287	19
20	Phone/Data Lines	1998	7,869	787	10	787		2,361	20
21	ADA Sidewalk	1999	2,016	101	20	101		303	21
22	Phone/Data Lines	1999	1,450	145	10	145		435	22
23	Air Conditioning	1999	10,866	1,087	10	1,087		2,989	23
24	Aluminum Gutters/Downspouts	1999	540	54	10	54		149	24
25	Exit Lights	1999	322	32	10	32		83	25
26	Exit Lights	1999	400	40	10	40		100	26
27	Smoking Room	1999	114	11	10	11		35	27
28	Third Floor Renovation - Bldg	1999	240,021	12,001	20	12,001		30,002	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,552,975	\$ 80,519		\$ 80,519	\$	\$ 1,567,035	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$2,552,975	\$80,519		\$80,519	\$	\$1,567,035	1
2	Fire Protection	1999	2,750	275	10	275		665	2
3	Architect Fees	1999	2,065	207	10	207		360	3
4	Maintenance Labor - Painting	1999	1,740	348	5	348		841	4
5	Paint Stairwells & Halls	1999	1,624	325	5	325		758	5
6	Third Floor Renovation - Bldg - Final PMT	1999	32,418	1,621	20	1,621		4,052	6
7	Carpeting - Main Floor	1999	10,300	2,060	5	2,060		4,292	7
8	Signage	2000	968	194	5	194		194	8
9	Storm Windows	2000	941	188	5	188		188	9
10	New Park Street Door	2000	2,872	191	15	191		191	10
11	Replace Warped Doors	2000	3,960	792	5	792		792	11
12	Reception Area	2000	22,256	2,226	10	2,226		2,226	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$2,634,869	\$88,946		\$88,946	\$	\$1,581,594	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$443,390	\$37,533	\$37,533	\$	Various	\$375,950	71
72	Current Year Purchases	32,430	6,449	6,449		Various	6,449	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$475,820	\$43,982	\$43,982	\$		\$382,399	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Van with Lift	Ford	1998	\$14,000	\$3,500	\$3,500	\$		\$14,000	76
77										77
78										78
79										79
80	TOTALS			\$14,000	\$3,500	\$3,500	\$		\$14,000	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$3,130,061	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$136,428	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$136,428	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,977,993	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Furniture & Fixtures	\$428,008	\$10,483	\$360,613	86
87	Other Non-care Vehicles	9,753	292	9,753	87
88					88
89					89
90					90
91	TOTALS	\$437,761	\$10,775	\$370,366	91

G. Construction-in-Progress

	Description	Cost	
92	CIP - Alzheimers Unit	\$62,683	92
93			93
94			94
95		\$62,683	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☒ NO
16. Rental Amount for movable equipment: \$2,320
- Description: Lease of copier equipment

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	\$
13.	/2003	\$
14.	/2004	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

Hiring trained aides rather than providing training

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 865	\$ 455,294	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 58,289)	209,273	241,625	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		40,344	5
6	Prepaid Insurance	25,119	58,930	6
7	Other Prepaid Expenses		5,949	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Amount Due from Affiliates	3,875,069		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,110,326	\$ 802,142	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		32,005	11
12	Long-Term Investments			12
13	Land	5,372	140,112	13
14	Buildings, at Historical Cost	2,634,869	10,506,475	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	927,581	2,199,721	16
17	Accumulated Depreciation (book methods)	(2,348,359)	(6,612,620)	17
18	Deferred Charges		67,054	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	139,435	139,435	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction in Progress	62,683	79,359	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,421,581	\$ 6,551,541	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,531,907	\$ 7,353,683	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 116,136	\$ 148,048	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,110	169,258	28
29	Short-Term Notes Payable	100,601	322,717	29
30	Accrued Salaries Payable	125,173	334,265	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 343,020	\$ 974,288	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	145,273	5,428,684	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Gift Annuities Liability		19,977	43
44	Deferred Revenue from Advanced Fees		297,809	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 145,273	\$ 5,746,470	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 488,293	\$ 6,720,758	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,043,614	\$ 632,925	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,531,907	\$ 7,353,683	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,216,707	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,216,707	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(143,303)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Dec. in FV of Perm. Restricted Assets	(29,790)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (173,093)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 5,043,614	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$3,852,081	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$3,852,081	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	15,795	13
14	Non-Patient Meals	5,662	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	315,566	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	104,068	21
22	Laundry	61,504	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$502,595	23
	D. Non-Operating Revenue		
24	Contributions	39,131	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$39,131	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$4,393,807	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	832,535	31
32	Health Care	1,900,695	32
33	General Administration	1,045,418	33
	B. Capital Expense		
34	Ownership	703,996	34
	C. Ancillary Expense		
35	Special Cost Centers	54,466	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$4,537,110	40
41	Income before Income Taxes (line 30 minus line 40)**	(143,303)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$(143,303)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,024	2,080	\$ 61,721	\$ 29.67	1
2	Assistant Director of Nursing	2,061	2,096	45,751	21.83	2
3	Registered Nurses	12,650	14,127	283,703	20.08	3
4	Licensed Practical Nurses	10,776	12,034	199,242	16.56	4
5	Nurse Aides & Orderlies	52,096	56,534	641,778	11.35	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,992	2,080	43,046	20.70	9
10	Activity Assistants	7,919	9,351	75,862	8.11	10
11	Social Service Workers	5,430	5,984	90,370	15.10	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,987	2,076	25,944	12.50	14
15	Cook Helpers/Assistants	20,366	21,731	161,946	7.45	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	12,044	13,719	102,255	7.45	18
19	Laundry	6,108	6,536	55,922	8.56	19
20	Administrator	2,848	3,296	104,455	31.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,782	9,332	87,401	9.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	609	636	6,318	9.93	31
32	Other Health Care(specify)					32
33	Other(specify)	1,009	1,057	12,778	12.09	33
34	TOTAL (lines 1 - 33)	148,701	162,669	\$ 1,998,492 *	\$ 12.29	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	192	\$ 8,177	ln 1 col 3	35
36	Medical Director				36
37	Medical Records Consultant	13	409	ln 10 col 3	37
38	Nurse Consultant	40	1,988	ln 10 col 3	38
39	Pharmacist Consultant	Monthly	3,813	ln 19 col 3	39
40	Physical Therapy Consultant	18	844	ln 19 col 3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	9	383	ln 11 col 3	44
45	Social Service Consultant	9	360	ln 12 col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	281	\$ 15,974		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	2,320	93,141	ln10 col 3	51
52	Nurse Aides	4,608	105,984	ln10 col 3	52
53	TOTAL (lines 50 - 52)	6,928	\$ 199,125		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Thomas DeFauw	Administrator	0	\$ 80,954	Workers' Compensation Insurance	\$ 38,676	IDPH License Fee	\$ 5,890	
Catherine Gurgone	Administrator	0	14,519	Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes	176,748	Health Care Worker Background Check		
				Employee Health Insurance	137,165	(Indicate # of checks performed)		
Thomas DeFauw PTO			(3,496)	Employee Meals				
Catherine Gurgone PTO			(4,102)	Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	3,202	
Accrual			(96)	Retirement Plan	40,931	Advertising	83,539	
				Employee Recognition and Other	74,398	Contributions	7,954	
						Allocation from Corporate	10,435	
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	(46,913)	
(List each licensed administrator separately.)			\$ 87,779			Non-allowable advertising	(27,110)	
B. Administrative - Other						Yellow page advertising	(8,947)	
Description			Amount					
			\$			TOTAL (agree to Sch. V, line 20, col. 8)		
						\$ 28,050		
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount
Community Care, et al	Management	\$ 19,256				\$	Out-of-State Travel	\$
United Methodist	Management	9,821						
Method Management	Management	500						
American Express	Management	14,100					In-State Travel	4,797
WLO & Assoc.	Management	2,000					Auto Expense	2,488
Campion, Curran, Rausch...	Legal	13,814					Auto Insurance	2,161
Cheney & Osborne	Legal	8,112						
Miller, Johnson, Snell...	Legal	5,181					Seminar Expense	6,441
Fox River Valley Center	Other	150					Allocation from Corporate	13,901
Leading Edge, et al	Human Resources	41,058						
Miscellaneous	Employee Recruitment	14,713						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			Entertainment Expense	()
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 128,705				(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 29,788

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network \$2,297
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 34,448 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 41,063
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None Has any meal income been offset against related costs? None Indicate the amount. \$ None
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: McGladrey & Pullen, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees